New Hope for Schizophrenia

The 1994 Nobel prize in economics was awarded recently in Stockholm to two mathematicians—Harold W. Kuhn and John Forbes Nash, Jr. Remarkably, Mr. Nash is schizophrenic. In a *New York Times* article (November 13, 1993) the story is told of his early genius, his brilliant thesis on number theory, published at the age of 21, and then the tragic disintegration of his personal and professional life as the disease began to manifest its destructive power.

Incurable, incapacitating, and extremely difficult to treat, schizophrenia plays terrifying tricks on its victims. The devastation unleashed upon patients and their families is heart–wrenching. And the national figures are sobering. Schizophrenia costs the health care system more than $18 billion per year. The average hospitalization cost for a schizophrenic patient is at least $70,000, and 40 percent of all long–term days in the health care system are taken up by schizophrenic patients. In addition, many homeless street people are schizophrenic and virtually outside the health care system.

Sometimes schizophrenics claim to hear the voice of God or Satan or feel singled out by a supernatural being. These symptoms bring confusion in the minds of both Christians and mental health professionals. Sometimes fellow believers wonder whether demonic possession is at work. Conversely, mental health professionals, particularly those who are agnostic or atheistic, may confuse normal religious experience with the psychotic symptoms of schizophrenia. It is important to review what is now known about this most severe of the major mental disorders and highlight the hopeful promise of new treatments.

The Disease

Lasting for at least six months and often for many years, schizophrenia is a psychiatric illness that significantly impairs social and occupational functioning. Typically, there are periods of relative improvement and worsening with a significant number of patients remaining chronically ill. The illness is characterized by two types of symptoms; first, the so–called "positive" symptoms—delusions, hallucinations, disorganized speech and behavior; and second, "negative" symptoms—such as emotional blunting, and reduction or absence of thought, speech, and volition. Schizophrenia usually begins in late adolescence or early adulthood, and is approximately equally distributed between men and women, with men in general having a somewhat more severe form of the illness. Because of the severity and persistence of these symptoms, patients often are ostracized by others, appear odd, and live lonely, isolated lives. Frequently, they do not marry and, for many, steady employment is never achieved.

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The Causes of Schizophrenia

There is now almost universal agreement that schizophrenia is a brain disease. The concept of the "schizophrenogenic" mother, who was thought to induce the illness in a child because of harmful communication and relationship patterns, is now virtually defunct. Recent research, particularly that utilizes the new brain–imaging techniques (MRI, PET, and CT scans), has demonstrated consistent abnormalities of brain structure, among them a shrinkage of certain areas of the temporal lobe. These studies, combined with genetic and neurophysiologic research findings, all point to a complex brain disorder that is at least partially inherited. There are also probable environmental factors, including intrauterine effects.

Although it is now clear that schizophrenia is not caused by dysfunctional parental and family relationships, research has shown that schizophrenic patients do not tolerate emotionally intense relationships well. For this reason, families in which conflict or a highly charged emotional climate prevails may contribute to relapse or make recovery more difficult.

New Treatments

Prior to the 1950s, schizophrenic patients were treated with long–term (sometimes life–long) hospitalization, frequently in state institutions. Little hope was held out for the recovery of those patients who

had been ill for more than two years. A major advance in therapy took place in 1952 with the introduction of chlorpromazine (Thorazine), the first drug demonstrated to be effective in treating schizophrenic symptoms. For the first time a significant number of patients responded with either partial or complete recovery.

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Over the next several years a whole series of medications with similar therapeutic effects, such as haloperidol (Haldol), were developed and marketed. Major problems remained, however, because these medications had significant and long–term side effects and were not effective in reversing the "negative" symptoms.

In the late 1980s an entirely new medication, clozapine (Clozaril), came on the market, followed in 1993 by risperidone (Risperdal). Two features of these new drugs mark them as genuine breakthroughs in the treatment of schizophrenia. First, they are effective in about one–third of cases where all previous treatments have failed. Second, they are the first medications to reverse the "negative" symptoms of the disease (blunting of emotion and volition). These negative symptoms are often the chief obstacles to long–term rehabilitation. But these drugs are not a panacea. They have potentially serious side–effects, require close psychiatric supervision, and are not effective in all cases.

Complementing the advances in the pharmacologic treatment of schizophrenia have been two innovations in psychosocial therapy. The first, called ICM (Intensive Case Management), assigns responsibility for the coordination of the various aspects of mental health care to a single professional whose task it is to see that patients keep their appointments, comply with their treatment plan, and receive intensified services when relapse threatens. The second psychosocial model, ACT (Assertive Community Treatment), extends the case management role to an entire team and ideally includes coordination of housing, personal finances, and general medical as well as psychiatric health care.

Both ICM and ACT place significant emphasis on stabilizing the patient's living situation. When the patient most appropriately lives with family, resources are focused on supporting the family environment by providing an in–depth understanding of the nature of the disease to other family members and teaching them appropriate coping skills. When possible, patients are encouraged to live independently, with the resources of the ICM or ACT support systems available to lend stability. Since many of these patients are chronically ill and have limited resources, often they are cared for in the public mental health system.

Christian counselors can be helpful by explaining to family, pastoral staff, and concerned laymen the nature of the disease, the hope of newer treatments, and the importance of early, vigorous psychiatric intervention. ❖

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